

S. No. 300
REV. 10-48

FILED JUL 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21908**

0610

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____ REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 5921 Registrar's No. 74

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Callao Rural</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Callao Rural</u> <u>0610</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION -----		d. STREET ADDRESS (If rural, give location) -----	
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>Monroe</u> c. (Last) <u>Dallas</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>30</u> (Year) <u>50</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>2-25-1862</u>
9. AGE (in years last birthday) <u>88</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Tuscarawas County, Ohio</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Ezra Putman Dallas</u>	
13b. MOTHER'S MAIDEN NAME <u>Melinda Ellen Shores</u>		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Marvin Mayhew</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prostatic Chronic Nephritis 2 yrs</u> INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES: Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prostatic Hypertrophy 3 yrs</u> DUE TO (c) <u>unknown</u> II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Valvular Heart Disease ?</u> <u>Bronchial Asthma ?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT (Specify) <u>no</u>	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____	
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-28, 1950</u> , to <u>5-28, 1950</u> , that I last saw the deceased alive on <u>5-28, 1950</u> , and that death occurred at <u>10 P</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>J. E. King M.D.</u> (Degree or title)		23b. ADDRESS <u>Macon Mo</u>	
23c. DATE SIGNED <u>6-5-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>June 1st, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Callao (Rural) Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. G. Edwards</u>	
DATE REC'D BY LOCAL REG. <u>7/3/50</u>		REGISTRAR'S SIGNATURE <u>Josephine King</u>	
ADDRESS <u>Bevier, Mo.</u>		ADDRESS <u>Bevier, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 7/17/50
MACON COUNTY HEALTH DEPARTMENT
County File No. 7/50/144
Date Filed 7/25/50

RECEIVED JUL 27 1950
District Health Officer No. 10
District File Number
Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

working under my personal supervision.

Student Embalmer No.....

Signed *H. Edwards*

Signed.....
Student Embalmer

Licensed Embalmer No. 1961

P. O. Address *Brewis Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.